

§ 424.5

42 CFR Ch. IV (10–1–99 Edition)

§ 424.5 Basic conditions.

(a) As a basis for Medicare payment, the following conditions must be met:

(1) *Types of services.* The services must be—

(i) Covered services, as specified in part 409 or part 410 of this chapter; or

(ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with §§ 405.332 through 405.334 of this chapter, pertaining to limitation of liability.

(2) *Sources of services.* The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.

(3) *Recipient of services.* Except as provided in § 409.68 of this chapter, the services must have been furnished while the individual was eligible to have payment made for them. (Section 409.68 provides for payment of inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)

(4) *Certification of need for services.* When required, the provider must obtain certification and recertification of the need for the services in accordance with subpart B of this part.

(5) *Claim for payment.* The provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment, in accordance with subpart C of this part.

(6) *Sufficient information.* The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

(b) Additional conditions applicable in certain circumstances or to certain services are set forth in other sections of this part.

[53 FR 6635, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 60 FR 38271, July 26, 1995]

§ 424.7 General limitations.

(a) *Utilization review finding on medical necessity.* When a PRO or a UR committee notifies a hospital or SNF

of its finding that further services are not medically necessary, the following rules apply:

(1) *Hospitals subject to PPS.* Payment may not be made for inpatient hospital services furnished by a PPS hospital after the second day after the day on which the hospital received the notice.

(2) *Hospitals not subject to PPS and SNFs—(i) Basic rule.* Except as provided in paragraph (a)(2)(ii) of this section, payment may not be made for inpatient hospital services or posthospital SNF care furnished after the day on which the hospital or SNF received the notice.

(ii) *Exception.* Payment may be made for 1 or 2 additional days if the PRO or UR committee approves them as necessary for planning for post-discharge care.

(b) *Failure to make timely utilization review.* Payment may not be made for inpatient hospital services or posthospital SNF care furnished, after the 20th consecutive day of a stay, to an individual who is admitted to the hospital or SNF after HCFA has determined that the hospital or SNF has failed to make timely utilization review in long stay cases. (This provision does not apply to a hospital or SNF for which a PRO has assumed binding review.)

[53 FR 6635, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

Subpart B—Certification and Plan of Treatment Requirements

§ 424.10 Purpose and scope.

(a) *Purpose.* The physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders tests, drugs, and treatments, and determines the length of stay. Accordingly, sections 1814(a)(2) and 1835(a)(2) of the Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services.

Section 1814(a)(2) of the Act also permits nurse practitioners or clinical

nurse specialists to certify and recertify the need for post-hospital extended care services.

(b) *Scope.* This subpart sets forth the timing, content, and signature requirements for certification and recertification with respect to certain Medicare services furnished by providers.

[60 FR 38271, July 26, 1995]

§ 424.11 General procedures.

(a) *Responsibility of the provider.* The provider must—

- (1) Obtain the required certification and recertification statements;
- (2) Keep them on file for verification by the intermediary, if necessary; and
- (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.

(b) *Obtaining the certification and recertification statements.* No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be a separate signed statement for each certification or recertification.

(c) *Required information.* The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

(d) *Timeliness.* (1) The succeeding sections of this subpart also specify the time frames for certifications and for initial and subsequent recertifications.

(2) A hospital or SNF may provide for obtaining a certification or recertification earlier than required by these regulations, or vary the time frame (within the prescribed outer limits) for different diagnostic or clinical categories.

(3) Delayed certification and recertification statements are acceptable when there is a legitimate reason for

delay. (For instance, the patient was unaware of his or her entitlement when he or she was treated.) Delayed certification and recertification statements must include an explanation of the reason for the delay.

(4) A delayed certification may be included with one or more recertifications on a single signed statement.

(e) *Limitation on authorization to sign statements.* A certification or recertification statement may be signed only by one of the following:

- (1) A physician who is a doctor of medicine or osteopathy.
- (2) A dentist in the circumstances specified in § 424.13(c).

(3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under State law.

(4) A nurse practitioner or clinical nurse specialist, as defined in paragraph (e)(5) or (e)(6) of this section, in the circumstances specified in § 424.20(e).

(5) For purposes of this section, to qualify as a nurse practitioner, an individual must—

(i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a nurse practitioner in accordance with State law; and have a master's degree in nursing;

(ii) Be certified as a nurse practitioner by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (e)(5)(i) of this section; or

(iii) Meet the requirements for a nurse practitioner set forth in paragraph (e)(5)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(6) For purposes of this section, to qualify as a clinical nurse specialist, an individual must—

(i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the